STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

D E P A R T M E N T O F H E A L T H

STATE OF RHODE ISLAND AND
PROVIDENCE PLANTATIONS,
DEPARTMENT OF HEALTH,
BOARD OF MEDICAL LICENSURE
AND DISCIPLINE

NO. C94-047

In the matter of:
PHILIP O. BAUMGARTNER, M.D.

ORDER

Pursuant to a Specification of Charges of Unprofessional Conduct dated April 12, 1994, issued on behalf of the Board of Medical Licensure and Discipline by the Investigating Committee of said Board Defendant, Philip O. Baumgartner, M.D. (hereinafter referred to as "Dr. Baumgartner") was summoned to appear before the designated Hearing Committee of the Board to answer three counts arising out of Dr. Baumgartner's care and treatment of patients, six of whom were identified in particular, and his failure to maintain minimally acceptable medical records for his patients.

The specific Counts against Dr. Baumgartner are as follows:

Count One: Dr. Baumgartner was charged with unprofessional conduct in the practice of medicine in violation of §5-37-5.1 (19) of the General Laws of Rhode Island 1956, as amended (1987 Re-enactment) by virtue of the fact that he prescribed scheduled drugs to six identified patients over prolonged and continuing periods of time without documentation of having taken an appropriate history, giving a physical examination, and without a demonstrable need for continuing to prescribe the drugs involved.

Count Two: Dr. Baumgartner was charged with unprofessional conduct in the practice of medicine in violation of §5-37-5.1 (19) in that he prescribed scheduled drugs to six identified patients over prolonged periods of time without documenting laboratory, diagnostic and/or consultative services necessary to validate continuing provision of said drugs to the patients.

Count Three: Dr. Baumgartner was charged with violating §5-37-5.1 (19) by failing to keep minimally acceptable medical records for his patients in the ordinary course of his medical practice.

This matter was set down for hearing commencing on June 8, 1994.

The three members of the Hearing Committee were as follows:

Stephen J. Hoye, M.D., Chairman
Barry Jasilli, Esq.
Elizabeth H. Roberts

Maureen A. Hobson, Esq. served as legal counsel to the Hearing Committee.

On behalf of the State:
Bruce McIntyre, Esq.

On behalf of Philip O. Baumgartner, M.D.:
Quentin Anthony, Esq.

There were a number of exhibits introduced by Counsel for each of the parties. The exhibits were duly marked, entered into the record of the proceedings and reviewed by the Committee in reaching a decision. Dr. Baumgartner appeared at each of the hearings with legal counsel and testified in his own behalf.

Prior to the presentation of any witnesses, the State presented documentary evidence on the record of an Order of Suspension dated March 19, 1994, which Order suspended Dr.Baumgartner from the practice of medicine effective immediately pending further order of the Board. The Order of Suspension recited the factual and legal basis for the suspension: That Dr. Baumgartner had been previously suspended from the practice of medicine for three months commencing November 16, 1992 for keeping incomplete and inadequate medical records and for lack of adequate documentation for the prescription and/or disbursement of controlled substances.

The November 1992 Order of Suspension was stayed while Dr. Baumgartner attended a Mini-Residency regarding the prescribing of controlled substances at the Robert Wood Johnson Medical School in New Jersey. As a condition of the stay, Dr. Baumgartner was ordered to provide monthly reports to the Board of all prescriptions written for controlled substances. As a result of reviewing those records in 1994, the Board issued a subpoena for records of patients for whom Dr. Baumgartner had written controlled substances. Upon review, the Board determined that Dr. Baumgartner was persisting in his former pattern of prescribing controlled substances without indication or documentation for the medications ordered, hence, the suspension.

Pursuant to the Specification of Charges and Time and Notice of Hearing dated April 12, 1994, Dr. Baumgartner was directed to appear for hearing on May 16, 1994. He requested a continuance of that date, bringing the matter to hearing commencing June 8, 1994.

The first witness for the State was Arthur Frazzano, M.D. Dr. Frazzano is Board Certified in the area of Family Practice and the parties stipulated to qualifying him as an expert in that field of practice. Dr. Frazzano testified that he reviewed Dr. Baumgartner's records regarding the six specific patients identified in the Specification of Charges. Dr. Frazzano found no individual charts for the patients. Patient information was contained in a log book, so-called. The log book was in the nature of a calendar which contained notes of appointments with patients. There was no regular information on patients' demographics, no patient histories, no progress notes or references to resolution of the patients' problems, and no rationale for treatment contained in the log books. The log books indicate no reasoned assessment of the patient or a treatment plan. There were no individual patient records, only notations in the log book; in essence, an appointment book containing patient names.

Dr. Frazzano testified that such a method of record keeping failed to meet the minimum standards of acceptable medical practice. He testified that adequacy of patient records is important to the patient's continuity of care. Lack of same constitutes a danger to those patients. He also testified that use of medication over a prolonged period of time without documented justification for it is not acceptable medical practice.

The State then entered Exhibits 6 through 11 which purported to be reports of the medical history and evaluations of the six patients in question. On the record, both Dr. Baumgartner and his legal counsel admitted that the aforesaid reports were not in existence at the time the subpoena was issued in March of 1994, but, rather, that Exhibits 6-11 were generated by Dr. Baumgartner during the period of his suspension, in preparation for this hearing before the Board.

Dr. Frazzano. reviewed those records immediately prior to the hearing, and, while saying they were an improvement over the log books, he testified that said records still lacked a rationale for care and assessment and treatment of the patient. Even in these records, the only thing reflected is that the patient was seen and a prescription given.

All of the drugs prescribed were controlled substances. Dr.Frazzano testified that providing these drugs over a long period of time, such as Dr. Baumgartner was doing, constituted a danger to the patients, both in terms of daily living and potential side effects resulting from use of the drugs.

On cross-examination, Dr. Frazzano reiterated that the records were lacking. He stated that there was no evidence that the omissions were intentional. He also testified that Dr. Baumgartner's handwriting in the log books was not entirely legible, and that he had a great deal of trouble reading the logs. He was able to decipher only about 50% of the notations. The illegibility itself was a problem. Dr. Frazzano testified that

In viewing the evaluation report for one of the six specified patients, W.S., the Board noted on the record that although the report was dated February 1993 as if the patient record were initiated at that time, a subsequent order for narcotics in December of 1993 was not contained in the record. In response to an inquiry by the Board into that area, Dr. Baumgartner testified that the evaluation reports were developed at some time for each patient, not necessarily on the first visit. Therefore, the report dated February 1993 may have been developed after December 1993.

In addition, at the hearing on June 15, 1994, Dr. Baumgartner for the first time produced a number of records of laboratory tests ordered for various patients. He testified that these laboratory test records, like the evaluation reports, were kept in a pile in his office and were not kept in individual patient files or jackets. He had no individual patient charts or jackets, only the log book. He also testified that although the State had issued a subpoena for his medical records, he did not give them the records of laboratory testing.

Dr. Baumgartner testified that exhibits 6 through 11 (patient evaluation reports) represented patient records, which except for the first page, were generated after summary suspension of his license.

Upon opening the hearing on July 21, 1994, Dr. Baumgartner's counsel made an oral Motion to Dismiss to which the State objected. Counsel argued that the Board had tainted itself by asking so many questions of the Respondent. Counsel likened it to cross-examination and argued that this was impermissible. However, the Hearing Committee determined that the questions it asked of the Respondent were by way of clarification and in order to understand the Respondent's testimony. By his counsel's own admission, (Transcript 7/21/94 at p.191), the Respondent was a "very difficult witness". The Motion to Dismiss was denied and Respondent proceeded to further testimony.

Relative to the six specific patients cited in the Specification of Charges, Dr. Baumgartner testified as to his treatment of each patient and his prescribing of controlled substances. With respect to patient N. M., for example, Dr. Baumgartner testified that at some time during her treatment, he conducted an examination. His treatment consisted of prescriptions for vicodin and valium. He testified that he provided these drugs in response to a diagnosis of a bulging disc condition. He testified that the patient told him she had a bulging disc, that she had treated with another physician, Dr. Stutz, and that she had been re-examined in the past by Dr. Stutz after an MRI. Dr. Baumgartner did not review the MRI or call Dr. Stutz. He initiated drug therapy on the basis of the patient's history of a bulging disc as given to him by the patient.

Likewise, patient D. P., sought Dr. Baumgartner's help for treatment of chronic headaches. Dr. Baumgartner testified with

medical records should be kept individually for each patient, be legible, be historic, and contain clinical material to justify the medications given. Neither the log books, nor the reports generated by Dr. Baumgartner in preparation for hearing, contained any evidence or documentation to indicate that Dr. Baumgartner had ever requested diagnostic testing for his patients.

At the conclusion of Dr. Frazzano's testimony, the State rested its case. Dr. Baumgartner's attorney then made an oral Motion to Dismiss on the record, arguing that while the State may have proven that Dr. Baumgartner's record keeping activities were inadequate, the State had not carried the burden of proof with respect to the charge of willful misconduct.

The State objected, arguing that Dr. Baumgartner's failure to maintain adequate patient records constituted willful misconduct. The State further argued that Dr. Baumgartner was under a prior Consent Order of suspension which was entered in the record for his failure to maintain patient records which justified his prescribing of narcotics to those patients. Therefore, Dr.Baumgartner was well aware of the Board's requirements. Nevertheless, he did not maintain adequate patient records.

After consideration of Dr. Baumgartner's Motion and the State's objection, the Board denied the Motion to Dismiss.

Dr. Baumgartner then testified in his own defense. He testified as to his age of 66 years and as to having entered the general practice of medicine in 1959. He had been retired from practice for a short time, and then approximately three years ago, he re-entered the practice attending to people "caught in the cracks" between specialists. He testified that he formerly kept detailed individual patient records containing a history, assessment, evaluation and treatment plan. However, when he re-entered the practice, he went on an extensive number of house calls; six or more per day. Rather than keep individual patient records he thought a log book, which he carried with him, would suffice. He testified that he was not interested in"exterior monitoring". He further testified that since being suspended by the Board in March of 1994, he had begun to develop better patient records.

The Board interpreted that statement to mean that since March of 1994 Dr. Baumgartner had been preparing records for patients he had seen prior to his suspension, inasmuch as he had seen no patients from March through the dates of hearing.

Dr. Baumgartner then presented a package of some seventy-five, more or less, records of patient evaluations. These were marked and entered into the record as one exhibit (Respondent's A). Dr. Baumgartner testified that these evaluations had been prepared prior to March of 1994, but that he neglected to give them to the investigators when they went to his office with the subpoena for his patient records in March.

respect to this patient that he had generated a patient history and physical evaluation report in 1992, but that he neglected to give it to the investigators in March of 1994. He treated patient D. P. with vicodin, then darvocet. She told him that her former physician, Dr. Sanders, had ordered a CT Scan. Dr. Baumgartner did not obtain a copy of the CT Scan, but initiated drug therapy on the strength of the patients' history as she presented it.

Dr. Baumgartner began treatment of J.B. in early 1992. The patients' symptoms were low back pain with radiation to the right buttock for 10 years prior. Dr. Baumgartner conducted an examination and history of the patient in May, 1993. He testified that he had ordered a CT Scan in June, 1992, which order he stated was contained in the log book. Dr.B.'s treatment of J.B. consisted of prescriptions for vicodin continuing for many months.

When questioned by the Board, Dr. B. testified that his medical practice is "more informal" now (than it had been prior to his retirement the first time). He stated that his notes in the log books are all he deemed necessary to refresh his memory as to each patient.

With respect to the patient, R. P., Dr. Baumgartner testified that he began treating him for back pain in early 1992. He stated that he referred R.P. to Newport Hospital for X-rays in March of 1992 and noted that fact in his log book. He also noted it in the patient's history and physical report dated May 27, 1993. He did not have a copy of the X-ray report when the investigators requested his records in March 1994, nor did he have any record of the results of the patient's X-rays. Thereafter, in May of 1994, Dr. Baumgartner requested a copy of the X-ray report from the hospital. He testified that his treatment of R. P. consisted of Vicodin three (3) times per day and Soma three (3) times per day. He stated that he gave R.P. weekly prescriptions of twenty one (21) pills each, but that the patient sometimes took four (4) pills per day, thus requiring a further prescription. Dr. Baumgartner said he "admonished" the patient for taking an excess of his daily prescription allotment.

Upon inquiry from the Board, Dr. Baumgartner acknowledged that his log indicates that he made a diagnosis of R.P. in October of 1992, but that the log indicates also that he ordered the X-rays in March of 1992. He was unable to explain to the Board how that sequence occurred.

Regarding his patient, W.S., Dr. Baumgartner testified that his initial treatment date was November 1, 1992. The patient was complaining of a painful right knee relating to an accident in May of 1991. Dr. Baumgartner's examination of the patient revealed some tenderness, but full range of motion. He referred the patient for X-rays on November 3, 1992. Subsequently, in February 1992, Dr. Maher referred the patient for an MRI, according to Dr. Baumgartner's testimony. He stated that he received copies of those reports, but that he did not put them in the log or in a

patient "chart". He testified that he believed he put them in a large pile with other physician's reports of other patients. He did not produce those records in response to the subpoena issued by the State, but did bring them to the hearing on July 21, 1994. Dr. Baumgartner testified that his treatment of W. S. consisted of prescriptions for daily doses of tylenol #3 or tylenol #4 and valium.

On July 28, 1994, Dr. Baumgartner brought with him to the hearing a large pile of X-ray reports and another large pile of diagnostic reports prepared by other physicians for his patients. Dr. Baumgartner represented that these were in his possession on the date the investigators were there, but he did not give them to the investigators at that time. He testified that the records were not maintained in individual patient files or charts, but rather were kept alphabetically in these piles.

Dr. Baumgartner testified with respect to another patient, W.B., that he was a cab driver who suffered from chronic back pain. Dr. Baumgartner treated him with tylenol #4.

On cross-examination, Dr. Baumgartner admitted that between April 30, 1993 and May 12, 1993, he had prescribed a total of 170 dosages of narcotics for W. S., including Vicodin, Valium, Dalmane and Tylenol #4. His records did not indicate any medical necessity or justification for the prescriptions.

Dr. Baumgartner testified similarly on cross-examination regarding the other patients in issue, specifically as to J. B. and W.B.. For example, he testified that he was aware that W.B. had knee surgery performed by Dr. Studders. He obtained a copy of Dr. Studders' surgery report, but not his progress notes, and he never inquired of the patient whether he was obtaining medications from other physicians in addition to himself.

Following Dr. Baumgartner's testimony, the Respondent rested its case.

Both parties presented closing arguments, including legal argument.

Based upon the testimony and evidence presented, the Board made the following **Findings and Conclusions:**

1.) That on November 16, 1992 the Respondent's license to practice medicine within the State of Rhode Island was suspended as a result of his failure to maintain adequate medical records as would justify the prescription and disbursement of controlled substances. The Respondent's suspension was "stayed" at that time provided he attended a mini-residency program and thereafter to submit to the Board monthly reports of his prescribing of controlled substances.

2.) That as a result of review of the monthly reports submitted by Respondent, in particular the volume of controlled substances being prescribed, investigative staff of the Board went to Respondent's medical office with a subpoena for Respondent's medical records.

3.) That in response to the subpoena, the only thing which Respondent provided were the log books, so-called.

4.) That the log books were exactly the type of medical records which had been deemed inadequate by the Board and for which Respondent had been suspended in 1992.

5.) That Respondent's license to practice medicine was summarily suspended on March 19, 1994, and the Respondent has not been engaged in practice since that date, pending hearing and this decision.

6.) That in May, 1994, for the first time, Respondent delivered a written "History and Physical" form for each of the six (6) patients specified in the charges. During the course of the hearings, Respondent submitted to the Board "History and Physical" forms for other patients. He also brought with him to hearing some diagnostic records. He testified that these records were in existence prior to March, 1994, but that they were kept in a pile in his office and he did not realize that he should give them to the investigators.

7.) That irrespective of whether the aforesaid records were in existence and in the possession of the Respondent, they were not contained in individual patient files or jackets and were not readily accessible for continuity of patient care.

8.) That the only method of determining Respondent's dates and type of treatment rendered to each patient was to review the log book page by page looking for notes as to that patient.

9.) That the State's expert witness testified, and the Board has expertise of its own to determine, that Respondent's method of record keeping falls far below the minimal standards acceptable in the medical community.

10.) That the records kept by Respondent are inadequate to develop a patient history and/or treatment plan and do not justify the long term prescription of controlled substances.

11.) That even after reviewing additional patient information which Respondent had brought to hearing and reconstituting his notes, Respondent was unable to answer basic questions about his patients and their patient care. He gave conflicting testimony, and questions of critical patient information were left unanswered. After months of preparation for hearing, and knowing the six (6) patients in issue, Respondent was unable to give cogent information to the Board regarding his patients. The Board sometimes waited

five (5) or more minutes for Respondent to shuffle through his paperwork only to provide an inadequate response to questions put to him concerning the care and treatment of his patients.

12.) That Respondent testified, and the Board finds, that Respondent was familiar with acceptable methods of medical record keeping, that he did keep patient records in "Jacket" form when he was in practice prior to his first retirement, but that he determined it was not necessary to maintain individual patient files or jackets when he re-entered the practice of medicine, even though he was suspended for his failure to do so in 1992.

13.) That the events leading up to this hearing all occurred while Respondent was still practicing under a prior Consent Order entered into with the Board, and that Respondent, despite attempts by the Board to assist him, has not been rehabilitated.

14.) The Board finds that based upon the testimony and evidence,, Dr. Baumgartner is guilty of unprofessional conduct in violation of Section 5-37-5,1 (19) of the General Laws.

ORDER

1.) That the license of Philip O. Baumgartner to practice medicine within the State of Rhode Island be, and hereby is, Revoked.

2.) That Philip O. Baumgartner be assessed an Administrative Fee of One Thousand ($1,000.00) dollars payable within sixty (60) days of the date of this Order.

Entered as an Order of the Board of Medical Licensure and Discipline for the State of Rhode Island this 21 day of November, 1994.

Barbara A. DeBuono M

Barbara A. De Buono, M.D. M.P.H.
Director of Health

Stephen J. Hoye M.D.

Stephen J. Hoye, M.D.

Elizabeth H. Roberts

Elizabeth H. Roberts

Barry Jasilli

Barry Jasilli, Esq.

NOTICE OF RIGHT TO APPEAL

The Respondent has a right to appeal the decision and Order of the Director of Health and Hearing Committee pursuant to R.I.G.L. 5-37-7.

CERTIFICATION

I certify that a copy of this Order was sent to Quentin Anthony, Esq., Sheffield and Harvey, 47 Long Wharf Mall, Newport, Rhode Island on this 23rd day of November 1994.

Ann M. Raponi